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‘Oh no, no, no, we haven’t got time to be doing that’. Challenges encountered introducing a breastfeeding support intervention on a postnatal ward.

Abstract

Objective: To identify elements in the environment of a postnatal ward which impacted on the introduction of a breastfeeding support intervention.

Design: A concurrent, realist evaluation including practice observations and semi-structured interviews.

Setting: A typical British maternity ward.

Participants: Five midwives and two maternity support workers were observed. Seven midwives and three maternity support workers were interviewed. Informed consent was obtained from all participants. Ethical approval was granted by the relevant authorities.

Findings: A high level of non-compliance with the intervention was driven by a lack of time and staff, and the ward staffs’ lack of control of the organisation of their time and space. This was compounded by a propensity towards task orientation, workload reduction and resistance to change – all of which supported the existing medical approach to care. Limited support for the intervention was underpinned by staff willingness to reconsider their views and a widespread frustration with current ways of working.

Key conclusions: This small, local study suggests that the environment and working conditions on a typical British postnatal ward present significant barriers to the introduction of breastfeeding support interventions requiring a relational approach to care.

Implications for practice: Midwives and maternity support workers need to be able to control their time and space, and feel able to provide the relational care they perceive that women need, before breastfeeding support interventions can be successfully implemented in practice. Frustration with current ways of working, and a willingness to consider other approaches, could be harnessed to initiate change that would benefit health professionals and the women and families in their care. However, without appropriate leadership or facilitation for change, this could alternatively encourage learned helplessness and passive resistance.

Key words: postnatal care; breastfeeding support; research context; realist evaluation; ward environment

Introduction

This article reports the findings of a qualitative evaluation of the implementation of a breastfeeding support intervention on a postnatal ward in the United Kingdom (UK). The evaluation sought to identify elements in the ward environment which supported or militated against embedding the intervention. The environments into which interventions are placed are increasingly thought to influence outcomes (Schmeid et al. 2009). However, trials of complex interventions such as breastfeeding support initiatives often provide insufficient data on the research settings to be able to explain any negative or unanticipated outcomes (Medical Research Council 2006; Oakley et al. 2006; Hoddinott et al. 2010).

UK, Australian and Swedish studies all describe postnatal wards as bureaucratic, stressful, task-orientated environments where midwifery encounters with women are often formulaic and brusque (Deery 2005; Lindberg et al. 2005; Dykes 2006; McKellar et al. 2009). This is likely to make introducing support interventions, which require a more relational approach to care, particularly challenging. The breastfeeding support intervention evaluated here was aimed at young women aged 20 and under. It was developed after conducting detailed literature reviews (Hunter 2014), and analysing the breastfeeding support needs of young mothers using data from focus groups with young mothers and an e-questionnaire with maternity staff (Hunter & Magill Cuerden 2014; Hunter et al. 2015). Key personnel in the study location were also consulted. The intervention comprised training midwives and maternity support workers (MSWs) to deliver structured, proactive breastfeeding support using a series of checklists. A four-bedded bay was set aside specifically for young mothers to facilitate delivery of the intervention and encourage peer support. To supplement the support provided by ward staff and provide continuity of carer, known family nurses were

informed when young mothers on their caseloads were admitted to the ward and encouraged to come and visit them.

Literature review

Challenges encountered implementing interventions are not often the focus of research papers. There is evidence, however, of a tendency amongst midwives not to support research interventions.

Hoddinott et al. (2011) conducted interviews with researchers involved in the nine UK randomised controlled trials (RCTs) of breastfeeding interventions conducted between 2000-2011, none of which reported significant improvements in breastfeeding rates. Participants commented that they had assumed staff would be committed to the research process but met midwifery ambivalence regarding their project or breastfeeding more generally, and difficulties procuring midwifery participation. A high workload and a lack of resources in the maternity service were thought to contribute to these findings.

During Hoddinott et al.'s own RCT investigating the provision of community breastfeeding support groups (2010), prospectively gathered quantitative and qualitative data indicated that, where breastfeeding rates fell, participants reported staff shortages and organisational change resulting in high workload, low morale and a 'can't do' attitude. Managers in areas with declining breastfeeding rates focussed on addressing staffing issues rather than leading the research initiative. All of the study localities reported problems securing midwifery support and involvement to recruit women, facilitate groups and attend steering meetings.

Two action research projects with innovations, Deery (2005) in the UK and McKellar et al. (2009) in Australia, also found problems in commitment and involvement from midwives. Deery indicates hostility towards the researcher which she considered was displaced anger with lack of managerial support and other organisational changes, whilst McKellar et al. found anger and resentment at changes in postnatal care. Both studies indicate midwives were

experiencing stress and heavy workloads. McKellar et al. identify a paucity of change ownership and suggest that adding research implementation to an already burdensome workload was overwhelming. In this study a negative culture in midwifery practice impeded the changes required to improve postnatal care.

In Swedish research looking at midwives' experiences of organisational and professional change, a new early discharge policy was introduced alongside an extended home visiting role for midwives (Lindberg et al. 2005). Although midwives were anxious and felt a sense of loss following the change, they were proud and satisfied with the new system. It is possible the more negative responses elsewhere may result from midwives feeling trapped in a changed system in which they can see no benefits for themselves or the women they care for. Research interventions in locations experiencing organisational changes, high workloads and low staff morale appear to become outlets for anger and frustration.

Methods

This evaluation formed part of a larger realist evaluation in which a breastfeeding support intervention was developed following focus groups with young mothers and an e-questionnaire distributed to maternity staff nationally and locally to the intervention setting. The intervention aimed to provide breastfeeding support to women aged 20 and under during their hospital stay.

A realist approach acknowledges the importance of context on outcomes, and seeks to identify the mechanisms or processes that are triggered when an intervention interacts with a particular environment (Pawson and Tilley 1997). These mechanisms will support and promote either positive or negative outcomes. The realist evaluation framework consists of a four-stage process of theory (what is happening now and why?), hypothesis (what might work and why?), observation (what happens when) and revised programme specification (Pawson and Tilley 1997; Kazi 2003). The methods and findings presented in this article relate to the third stage of the process – observation – during which, following staff training, the intervention was implemented and a

concurrent evaluation carried out. The evaluation was led by the first author of this paper and consisted of observations of practice and semi-structured interviews with ward staff, conducted over six months from October 2012 - April 2013. As the evaluation was concerned with the implementation, rather than the content, of the intervention, young women themselves were not interviewed during this phase.

There is no set methodology for carrying out realist evaluations. Rather, the most appropriate methods for each situation are selected (Pawson and Tilley 1997; Hoddinott et al. 2010). Observations are particularly suited to a realist approach, enabling the researcher to see what is happening at first hand (Donovan 2006; Dykes 2006). Observation may reveal more than might be reported in an interview, such as culturally learnt behaviour that may not be articulated (Agar 1996; Dykes 2006; Bowling 2009). An unstructured design was used, facilitating an inductive approach whereby events, ad hoc discussions and comments were noted by hand in a field diary as, or just after, they occurred. By recording everything, the researcher hoped to mitigate the risk of bias associated with observational enquiries (Bowling 2009).

In order to capture influences of context on the intervention at different time points, three six-hour observations were conducted - one at the beginning, one in the middle and one towards the end of the six month evaluation period. The six-hour time period covered the length of a short shift. All observations were carried out during the day time, as this was the busiest time on the ward when most decisions regarding the intervention were likely to be taken. To reduce bias, ward staff were given verbal and written information about the evaluation but had no advance notification of the observation dates. During the observations, five midwives and two MSWs who consented were followed by the researcher as they cared for young and older women. The researcher attempted to adopt a 'peripheral' status, blending into the environment as much as possible to limit the effects of her presence on the behaviour of those being observed (Burns et al. 2012). The researcher's 'insider status' as a

midwife working in another area of the Trust, and her frequent presence on the ward while the intervention was being set up, meant that most staff were used to and appeared comfortable with her presence. Assurances were given regarding participant anonymity and the independence of the research. Efforts were made to build trust and put staff at ease.

Following the observations, the field diary was read and re-read by the researcher in order to identify themes. Data were then cut and sorted, creating a thematic scrapbook. Where links between themes were identified, they were joined together to form more abstract categories of behaviour patterns. Analyses of practice observations, particularly when they are conducted by someone familiar with the practice area, risk replicating the assumptions and political standpoint of the researcher (Rooney 2005). In the current instance, the scrapbook helped to create a degree of objectivity by providing a visual indication of the number of times specific behaviours were observed. It also enabled patterns of behaviour to be identified. Discussion of emerging themes with the project supervisors (the second and third authors of this paper), who were independent of the service, also helped to provide assurance on the credibility and reliability of the analysis.

Semi-structured interviews were conducted with a purposive sample of seven midwives (including two ward managers) and three MSWs who had participated in the intervention. Semi-structured interviews and observations are widely held to complement and inform one another (Agar 1996; Dykes 2006). In the current instance, interviews enabled the researcher to understand the implementation process from the point of view of the participants and to reflect with them about what had happened (Bluff 2006; Arthur et al 2007), while the observation provided a more external perspective and an opportunity to compare everyday activities as observed with staff perspectives on these. The interviews also provided participants with an opportunity to identify mechanisms and themes that the researcher may have missed (Arthur et al. 2007). The interview topic guide included questions about participants' attitudes to the support package and difficulties they had encountered implementing different aspects of the intervention. The

interviews were conducted towards the end of the evaluation period. It was anticipated that familiarity with the researcher by this point would encourage participants to talk openly (Rooney 2005).

Interviews lasted between ten and thirty minutes and were recorded and transcribed verbatim. Some interviews were short as they were recorded during the participants' working day - busy staff tended to answer questions quickly and directly. Interviews with participants nine and ten, which each lasted 30 minutes, revealed no substantially new themes, indicating that data saturation had been reached. Transcripts were read and re-read to identify new themes and further material for existing themes. Interview data were then cut, sorted and added to the scrapbook. This amalgamation of observation and interview data ensured that the themes identified emanated from the ward staff as well as the researcher.

Setting

The intervention was implemented, and the evaluation carried out, on an inpatient maternity ward which principally cares for postnatal, medically low risk women. The ward is situated in a large tertiary referral maternity hospital, with around 8,000 births per year. In 2012, there were 108 maternities to women under the age of 18 in the county in which the hospital is situated (Office for National Statistics (ONS) 2014). Data from the ONS indicates that this number can be trebled for women aged 20 and under. Age-related data for inpatients was not kept by the ward in 2012, so exact numbers of young women cared for are not known. It was usual for between two and four mothers aged 20 and under to be staying on the ward at any one time. The hospital does not currently have UNICEF Baby Friendly status. The UK Care Quality Commission rated maternity care in the hospital Trust the same as, and in a few instances better than, other UK Trusts (Care Quality Commission 2013). The ward is set up to care for 37 women in a mix of single and family rooms and four-bedded bays. Typical shift cover consists of three-four midwives and two MSWs. Most midwives hold rotational posts, spending six months of every year working on the ward. The Trust discharges mothers home from the labour ward where possible. Postnatal women on the ward

therefore generally had long or complicated deliveries or caesarean sections, or social issues preventing an early departure.

Recruitment and inclusion criteria

Ward managers and staff were eligible to take part in the evaluation if they provided care to young women and consented to being observed during a shift and/or to being interviewed. Information leaflets were placed on a staff notice board at the beginning of the evaluation period and verbal information was given during shift handovers, at ward meetings and at mandatory update days. Further information was given and consent forms were signed prior to participants being interviewed or observed. Potential participants were assured that all data would be anonymised, and that they were free to withdraw at any point.

During the observations, consent was not sought from the women receiving care from the staff being observed. However, participants were asked to introduce the researcher and explain that she was observing staff practice. The researcher stood outside patient interactions, usually on the other side of curtains drawn around the patient's bed. It was inevitable that incidents were witnessed and comments heard from staff and women who had not consented to being observed. Other researchers have taken very different stances with respect to this material: Dykes (2006), went out of her way to be out of earshot of encounters involving individuals who had not consented to take part in her research. Kusow (2003) included direct quotes from people who refused to be interviewed for her study. In the current project, an overheard comment from a woman is used. The comment was made in a public space by a woman who was aware of the researcher's presence and purpose. Ethical approval was given by the NHS Research Ethics committee and the researcher's university.

Findings

A high level of non-compliance with the intervention was encountered. Young mothers were not warded together during any of the observations and study paperwork was rarely instigated or completed. We will argue that the

mechanisms supporting this non-compliance were the stresses in the ward environment and the strategies that staff had developed for coping with them. The stresses are summarised under two themes: lack of time and staff, and lack of control of the organisation of time and space. Themes for coping strategies were task-orientation, workload reduction, and resistance to change. There were some mechanisms in evidence that supported the limited implementation of the intervention. These were a willingness by staff to reconsider their beliefs and a widespread frustration with the current situation. The quotes used below are all taken from the interviews, unless otherwise stated.

Mechanisms supporting non-compliance: stresses in ward environment

Lack of time and staff

The ward was described in the interviews as 'manic' (Participant 3, midwife) and as a 'fast process unit' (Participant 9, MSW). Without exception, participants attributed this to inadequate staff cover:

'I think the main problem... is that we're really short staffed, and we are too busy'

(Participant 4, MSW).

Time pressures created on days when midwives were expected to care for ten or more women each were acknowledged to impact on the quality of their work:

'I give the best care I possibly can on a very busy day, but it's not necessarily the same care I would give on another day'

(Participant 11, midwife (Observation 1)).

In particular, participants considered that low staff: patient ratios prevented them from spending time relating to and supporting women:

'Just not having the time – literally not having the time to spend with people... say you were on a 12 hour day shift... well 12 ½

hours we're here for – if you take off half an hour at the beginning and the end for handover...take off your hour for lunch, ...you're already down to ten and a half hours. If you're looking after ten women, that's an hour each. And if you've got to do their postnatal check, baby's postnatal check...write their paperwork, you might have to talk to the doctors, you've got to do the doctors' round... there genuinely actually isn't the time in the day'

(Participant 6, midwife).

In addition to the number of women they were caring for, administration and management tasks were observed further to restrict the time available for face to face contact with individual women. During observation one, administrative tasks such as paper and computer documentation, and ordering and finding drugs, resulted in the midwife who was shadowed (Participant 11) spending less than half of her six hour shift interacting with women. She had no break.

The busyness of the ward staff meant that the time taken to complete each element of the intervention, together with its perceived convenience, impacted on the likelihood of its being completed. Whilst staff described initially finding the checklists 'daunting', they found them more acceptable once they realised they improved communication between colleagues and took no longer to complete than existing documentation. There was an indication that some staff were unwilling to ward young mothers together because of the time this would take. The family nurse initiative, however, was well liked because it was quick and easy to implement:

'I think it's a really good way of doing it. Because it's obvious and it's right there, and as soon as you pick up the notes, you know that they've got a family nurse practitioner involved'.

(Participant 6, midwife).

Some staff recognised that work could be organised differently. A senior midwife commented

‘... maybe we’re not using our time.. as wise as we’d like. And sometimes you do have to stop and stand still and think ‘what’s really important here?’

(Participant 10, midwife).

Some established routines on the ward appeared to be particularly time consuming. For example, during a doctors’ round, midwives were expected to wait while the doctors reviewed the maternity notes, then watch while they consulted with the women, repeating many questions and procedures already undertaken during the midwife’s postnatal check. Additionally, during each observation an MSW spent the entire shift sorting paperwork for and bringing mothers and babies to a paediatrician or specialist midwife conducting newborn initial checks.

Lack of control of time and space

The ward appeared to be a rather chaotic, disordered environment - an impression strengthened by the myriad of different health professionals, domestic staff and trades people present, all of whom wanted access to patients, often with the midwives’ assistance. Domestic staff patrolled the ward offering bed changes, a Bounty representative offered a bag of free samples and a photography service, physiotherapists gave advice and anaesthetists provided a post-epidural visit, to name but a few. Some women resented the almost constant flow of uninvited visits - during observation three, one woman was overheard snapping at her partner that

‘you stay in hospital to get a rest, but you don’t get a rest, you get people coming in all the time – stupid people – like a physiotherapist come and tell me how to move my legs’

(patient, Observation 3).

It was evident that the ward staff had no control over who visited the ward and when. Although none of the visitors were necessarily unwelcome, the constant and unpredictable comings and goings resulted in midwives and MSWs having little control over their time, or space to carry out their work. Midwives were often interrupted when carrying out checks or interacting with women in their care, as other staff wanted access to the women they were with, or requested assistance to find equipment or notes needed for care elsewhere. On one occasion a midwife was called from a consultation to help find equipment required by doctors, while they waited in the coffee room. Such behaviour clearly indicates that medical activities were seen as more important than midwifery care.

Since the midwives' and MSWs' time was often diverted elsewhere, ancillary staff repeatedly became involved in patient care, an occurrence which further contributed to the sense of ward disorder. A house keeper was observed taking babies to and from women's beds, and a member of the hearing screening team brought a mother and baby to the baby café. However, when the lift got stuck, it was the midwives who were expected to sort this out.

Another symptom of the lack of control exercised over the physical environment of the ward was the finding that equipment was often missing or faulty. During observation one, stocks of a commonly used drug had run out, and, in observation two, a sink where midwives usually washed their hands was full of dirty coffee cups. These occurrences indicate an environment in which staff are omitting to undertake basic procedures.

The appearance of disorder was particularly evident when the ward managers were not working on a shift. For example, during observation one, when no manager was present, the midwives all migrated into the small ward office after receiving handover. The tasks they needed to complete in the office had not been divided up between them, resulting in everyone, as the midwife being shadowed observed,

'trying to do the same job' (Participant 11, midwife -Observation 1).

During observation two, when there was also no manager present, midwives seemed to cluster around the bed board, discussing where women were and where they could be moved to, but no decisions were made and no action taken. Although midwives were rostered to coordinate shifts when managers were absent, they were either unwilling to organise and lead the work, or lacked the authority to instruct and make decisions. The shift observed during observation three, in contrast, was led by a manager and appeared calmer and more orderly, although the manager herself was clearly extremely busy as she was both looking after a quota of women and fielding all the problems and queries relating to the general running of the day. This resulted in her feeling overwhelmed and out of control:

‘Can I just say, I do not feel in control today. I do not feel in control’

(Participant 1, midwife -Observation 3).

The busyness of the staff, and their lack of control over their working space and time, created a stressful environment that militated against the provision of the relational care that the intervention sought to introduce:

‘you’re trying to help somebody breastfeed but you’re also running the clinic, and you’ve got buzzers going off, and you’re meant to be doing this, and you’re doing that – you haven’t – even when you’re standing with somebody trying to help, in your head you’re going ‘oh my God, I should be doing this, I should be doing this, I should be doing this’ ... you just can’t .. relax and actually ... give that woman the help that you’re meant to be’

(Participant 8, MSW).

The implication above that breastfeeding support is seen as less important than other aspects of the MSW’s role is discussed below.

Mechanisms supporting non-compliance: coping strategies

The coping strategies identified – task orientation, workload reduction and resistance to change – have all previously been reported among stressed and overburdened midwives both in the UK and Australia (Hunter et al. 2008; McLachlan et al. 2008; McKellar et al. 2009; Deery and Hunter 2010). They enable midwives to regain some control over their daily activities (Dykes 2006; Deery and Hunter 2010). This study illustrates the effect of task orientation, the need for workload reduction and resistance to change on breastfeeding support, and shows how by propagating a medical hegemony they obstruct attempts to introduce a more relational approach to care.

Task orientation

Care on the ward appeared to have been stripped back to a series of tasks to be completed in the shortest possible time. Activities such as measuring urine, dispensing medication and ensuring that every woman is wearing TED stockings were prioritised, perhaps because they could be completed reasonably quickly, giving the midwife a sense of achievement and control. The relational aspect of care was often reduced to the task of information giving – telling women about recovery and baby care but not often offering practical or emotional support. This tactic has been dubbed the ‘linguistic non-touch technique’ (Kirkham 1989, p125).

Furthermore, tasks prioritised by the midwives were usually medically-focused, reflecting and reinforcing an existing medical hegemony. In this environment, breastfeeding support was seen as an added extra which the midwives didn’t have time to provide – it was either left to the MSWs, or given in

‘a rushed 5 minutes here and there when we can fit it in’

(Participant 3, midwife).

Breastfeeding was not, however, prioritised by the MSWs either:

‘we need to do lots of things, plus breastfeeding support’

(Participant 4, MSW).

Delegating breastfeeding support to MSWs appeared to have been prompted in part, or had led to, a lack of confidence among midwives both in the process of breastfeeding and their ability to support women to establish lactation. Participant 11, an experienced midwife, commented that she felt deskilled in supporting breastfeeding mothers as she always had to delegate this to MSWs. There was also evidence of a tendency among staff at all levels to deal with breastfeeding difficulties by performing tasks rather than encouraging and facilitating a close and loving relationship between mother and child. For example, an MSW was observed taking blood sugars from a healthy baby she had been unable to latch to its mother's breast. When the blood sugars were normal, she then proceeded to take the baby's temperature. This approach resonates with Foucault's critique of medical treatment being dominated by the observation and monitoring of physical symptoms (Foucault 2003). Foucault talks of the 'incessant disorder of comings and goings' (1980, p177) generated by a system that demands that patients are prodded, poked and endlessly observed and tested – a phenomenon that was in evidence in the frustration expressed by a woman who wanted to rest in the current study.

When it was offered, breastfeeding support was often condensed into a series of mini set-piece lectures on supply and demand or, where necessary, expressing. After these lectures, women were told to 'call when you need help'. This had become a mantra that enabled staff to feel supportive without actually spending time with women. If women did ring for help, the call bell would generally be answered by someone else, and often not in a timely manner:

'They buzz the bell. Half an hour after they've rung
somebody arrives, and it's all gone'

(Participant 2, midwife).

Practical support was often provided in the form of hands on help – possibly because this enabled the caregiver to retain control and finish the ‘task’ in the shortest amount of time. Once the baby was on the breast, the mother would be left -

‘no one really stays with someone through the feed’

(Participant 6, midwife).

The breastfeeding support package was not only, therefore, not embraced due to staff shortages but also because it addressed a subject that was not prioritised by staff, and advocated a proactive, facilitative, relational style at odds with the task-orientated approach commonly used on the ward.

Workload reduction

Midwives were observed trying to manage their stress by reducing their workload. Individuals would assign themselves whatever they considered to be a reasonable amount of work, and leave others to pick up whatever was left. An inexperienced midwife called out of the ward for a short period at the beginning of one day returned to find her colleagues had assigned her the role of coordinator for the shift (even though another midwife was named as coordinator on the off duty and there were more experienced midwives working) in addition to caring for 12 postnatal women (another midwife had only three). This suggests that the midwives had adopted an individualistic approach to managing their workload and its associated stresses, and were not acting as a team or supporting each other – a situation which further militated against the successful introduction of a new approach to breastfeeding support.

Resistance to change

Resistance to change was encountered in the form of subversive action, passive resistance and criticism of implementation methods. Subversive action included dissuading colleagues from instigating the changes:

‘it seems – you’ll say to somebody, ‘we should do this as the teenage bay [ward young mothers together]’, ‘oh no no no – we haven’t got time to be doing that’

(Participant 5, midwife).

Additionally, references to a bay for young mothers were repeatedly removed from the ward bed board. This wish to expunge all traces of the intervention was also expressed in a proposal to move it elsewhere. Interview participants discussed the need for breastfeeding support to be provided antenatally, or postnatally in the community, or in a different ward, or even, on one occasion, in a different hospital:

‘Or possibly even moving it.. from the [hosting hospital] completely, and maybe moving it – I mean I don’t know how big the [another Trust hospital] is..., or if one of the community places...’

(Participant 9, MSW).

Passive resistance included not identifying young mothers during handover and not warding them in the appropriate bay or instigating the paperwork:

‘And people aren’t necessarily saying to us, or people aren’t asking, the age, before they’re accepted to the ward’.

(Participant 2, midwife).

Criticism of the intervention itself, or the way in which it was implemented, was put forward to justify non-compliance:

‘some [staff] just say that they don’t think [teenagers] should be treated differently to any other woman on the ward’

(Participant 3, midwife).

It was suggested that the intervention was more likely to be implemented if posters were put up, or one-to-one or group information sessions were held

for staff – all these things had in fact been done and yet people chose not to be involved.

Mechanisms supporting compliance

Willingness to reconsider

Despite resisting change, there was evidence that individuals were willing to reconsider their opinions if views were challenged and evidence supporting the initiative was explained. This was described by interview participants and evident during the staff training sessions:

‘At first I suppose I, like possibly many people ... didn’t really understand why... any section of women were being specifically - targeted ... And I think the last [training day] ... I came out of that feeling like I, ... kind of understood where I may have - not seen before... the various needs – the differing needs of younger mums’

(Participant 9, MSW).

Frustration with current situation

Midwives and MSWs expressed a profound dissatisfaction with the current situation on the ward, as giving time and care to women

‘is why I think we’re all in the job in the first place’ (Participant 8, MSW).

Newly qualified midwives, graduates of a UNICEF Baby Friendly accredited university, were very frustrated not to use their knowledge and skills:

‘Having spent two years being drilled in baby unicef friendliness, to then sit and think I don’t have the time to put all that into practice is - really disheartening. It’s, it’s... not what I trained to do’

(Participant 6, midwife).

This comment echoes the distress experienced by midwives juggling an ideal of being 'with woman' with a requirement to be 'with institution' described by Hunter (2004).

Midwives and MSWs identified time, proactive support, consistent advice, education and positive relationships with caregivers as being key to breastfeeding success. Although it has been suggested that emotional aspects of care would continue to be neglected even if midwives were not busy (Hunter and Deery 2010), participants expressed a wish to be able to provide these in their practice:

'And if we had more time, or more staff, then you would happily spend that time with the mums and build up a stronger bond'

(Participant 9, MSW).

Finally, ward managers in particular recognised that young mothers needed additional support:

'these girls who are vulnerable, who... we should be - prioritising... so that, you know... we do our job properly. They get stuff thrown at them antenatally, and then once they've delivered - they're sort of cast adrift a bit in hospital'

(Participant 1, midwife).

The level of non-compliance with the intervention indicates that these enabling mechanisms were not strong enough, or used effectively enough, to challenge the status quo on the ward.

Discussion and implications for practice

The findings demonstrate significant barriers to introducing a breastfeeding support intervention on a postnatal ward. Even if willing to implement the intervention, midwives and MSWs were not in control of their time or space. Care on the ward was driven by their need to reclaim control where they

could. Hence task-orientation was prioritised over relational care, which involves ceding control to women. The prioritisation of medically prescribed tasks supported and perpetuated the existing medical hegemony on the ward. Within this medical mindset, breastfeeding was a peripheral activity, to be undertaken if time allowed.

A busy workload made staff unwilling to participate in research. Their decision not to participate, or actively to sabotage the initiative, gave them a sense of control over their environment - providing an opportunity for autonomy lacking elsewhere. Expressing hostility towards the intervention may also have functioned as an outlet for more fundamental frustrations. Psychological research has shown that a lack of control over working conditions leads to a stressed, demotivated workforce which becomes resistant to change (Bandura and Locke 2003; Cooper 2012). Conversely, empowering employees by giving them more control over their work has been shown to be an effective way of combating stress and a means of achieving lasting change (Savery and Luks 2001; Bandura and Locke 2003; Leggat et al. 2011). Prejudice against young mothers and a lack of health staff confidence in supporting breastfeeding provided further incentive for non-participation.

It has been suggested that midwifery hostility to research interventions might be overcome if a more inclusive and participatory approach was adopted (Hoddinott et al. 2011). However, both Deery (2005) and McKellar et al. (2009) used participatory action research in their projects, and both encountered resistance and hostility from midwives. Similarly, consultation with maternity staff fed into the development of the intervention in the current study.

Limitations

This small study was carried out on one site by a single researcher. The observation and interview schedule was therefore limited to the time she had available. However, data saturation was reached during the interviews, and the unstructured, inductive approach adopted during the observations meant that rich and extensive data was collected, including themes that may have

been missed if a more structured method, or interviews alone, had been used. It is possible, however, that further themes would have been identified if more observations had been conducted at different time points. The hosting site was a typical example of a UK maternity ward, and the findings resonate with other studies, suggesting a degree of transferability may be apparent.

Conclusion

Current findings suggest that unless midwives and MSWs are able to exercise some control over their working environment, it is unlikely that midwifery breastfeeding support interventions will be able to take root. Midwives and MSWs perhaps need to recognise and claim their own power by working together to set their own agenda for postnatal care, creating an environment in which agreed ideals are able to flourish. The mechanisms supporting change in the current study – a willingness on the part of midwives and MSWs to reconsider their views, and their frustration with the current situation, could be harnessed to instigate change.

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